ABSTRACT

SOCIAL WORK

JOHNSON, SAPHEALLAH B.A. UNIVERISTY OF NORTH CAROLINA AT GREENSBORO, 1999

A PROGRAM EVALUATION OF THE DEEPER LOVE PROGRAM:

A WORKSHOP FOR GAY AND BISEXUAL MEN OF AFRICAN DESCENT

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Thesis dated May 2003

The program evaluation examined the effectiveness of Deeper Love, which is designed to increase HIV knowledge and reduce the risky sexual behaviors of African-American men who have sex with men. The Deeper Love Program provides a series of 5-week workshops to address the concerns of the population and promote healthier and safer sexual practices. The mission of the program is to provide a safe space and a support network for African-American men who have sex with men.

The study was conducted at AID Atlanta, the largest AIDS social service organization in Georgia. AID Atlanta is the organization that developed Deeper Love. AID Atlanta's mission is to provide a broad, compassionate range of HIV/AIDS services. The evaluation focused on men who completed the program between 2000-2002. Upon entering the workshop each participant was given a Deeper Love Questionnaire Pre-test. The Deeper Love Questionnaire measured the current HIV Knowledge and the Sexual Risk-Taking Behavior of the participants. The 5-session workshop addressed the

knowledge of HIV/AIDS, relationships, community and peer norms, disclosure, and high-risk behaviors of HIV/AIDS. At the end of the workshop, the respondents completed the Satisfaction and Program Evaluation Scale. Three months later participants were mailed a follow-up questionnaire to assess behavior change. In addition, interviews with the program facilitators were conducted to assess process related issues. The data were analyzed using descriptive and frequency data. The information will be useful in the agency's continued efforts to promote behavior change in this population. The findings show that these men have a great understanding of the disease of HIV/AIDS and the risks associated with their sexual acts. However, these men continued to engage in risky sexual behaviors. The majority of participants felt that by having a monogamous partner, they were at less risk for HIV/AIDS. In addition, participants reported being afraid that their partner would not have sex with them if safe sex were encouraged. Implications for further research and interventions for African-American men who have sex with men are discussed.

A PROGRAM EVALUATION OF THE DEEPER LOVE PROGRAM: A WORKSHOP FOR GAY AND BISEXUAL MEN OF AFRICAN DESCENT

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

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ATLANTA, GEORGIA

MAY 2003

CLARK ATLANTA UNIVERSITY THESIS

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ACKNOWLEDGMENTS

I would first like to thank God, for He has truly blessed me to make it this far. Second, I would like to thank the members of the program evaluation team that provided great help and insight: Roderick Flowers, Ebony Glass, Lydia Jackson, Kajuana Pitts, and Tera Reid. I acknowledge my family and friends because of their patience and support, as my mood changed, stressing the outcome of the evaluation and school. I love you for being there and for never letting me stop. I thank my professors at the Whitney M. Young, Jr., School of Social Work. Dr. Davis, I thank you for expecting only the best and providing great support to the field of social work and program evaluation. I thank those who have made me laugh, cry, upset, mad, and frustrated. You have made me the person I am today and the social worker that I will be. You have helped me to understand myself and work better with a diverse population. I thank everyone who has been there along this challenging, but fulfilling path.

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CHAPTER ONE

INTRODUCTION

This evaluation explored the devastating effects of the AIDS epidemic and prevention efforts for African-American men who have sex with men (MSM). African Americans represent an estimated 12 percent of the U.S. population, but they make up almost 38 percent of all AIDS cases reported in the country. Among African-American men, men who have sex with men represent the largest proportion (37 percent) (Condor, 2001).

African Americans continue to face issues of exclusion. They experience restricted access to equal opportunities in employment, education, housing, health care, and a host of health and human services. These experiences have affected the overall effectiveness of HIV/AIDS education and prevention communication. African-American men who identify as homosexual, face racism from the African-American community and from white gays. Often, the African-American community views openly gay black men as a threat to the stability of the black family. Often identity is characterized by ambiguity: Men identify with African Americans in terms of history, family, and church, and they connect with gays on the basis of sexual desire. The Centers for Disease Control Prevention (CDC) and the U.S. mayors' conference conducted an assessment of HIV education and prevention interventions for gay and bisexual men of color. They

concluded that programs often fail to speak meaningfully to the experiences of MSM and that the programs were scarce and underfunded (Myrick, 1999).

According to studies by CDC (2000), the "down low" communities of black men, who have sex with men, are a contributing factor to the alarming numbers of infected African-American women. "Down Low" means men who have sex with men, but live lives of secrecy. These men are often times married with children, wives, or girlfriends.

A part of the problem could be the lack of positive role models for sexual behavior. Only 3 percent of HIV/AIDS scholars are black. African Americans have long struggled to define themselves and the same issues exist in HIV/AIDS research (Centers for Disease Control and Prevention, 2001). In response to African-American men being identified as a high-risk population, gay and African-American community-based organizations have been called upon to design and implement culturally tailored programs that communicate meaningfully with affected populations (Myrick, 1999).

A large number of African-American men who have sex with men (HIV positive or not) lack the support to be "black and gay." The problem has implications for the entire black community, because the target population does not have the resources and support to disclose their sexuality, or their HIV status. Therefore, the men continue to be on the "down low" and the numbers continue to rise.

These men need programs that are effective in reducing their risky sexual behaviors and increasing their knowledge of HIV/AIDS. Additionally, they need a safe place to be themselves (Center for Disease Control and Prevention, 2001).

It is time to fight the epidemic, find out what programs are effective on reducing high-risk behaviors, and prevent the spread of the disease within the African-American community. This chapter will provide the purpose of the evaluation, an overview of the program, statement of the problem, significance of the evaluation as it relates to the evaluation, and the field of social work.

Purpose of the Evaluation

This evaluation examined the immediate and short term effects of Deeper Love, a workshop for African-American MSM. Is this program effective in increasing knowledge of HIV/AIDS and reducing risky behaviors of African-American men who have sex with men? Each year billions of dollars in tax money, charitable contribution, and philanthropic foundation dollars are spent to do good things in the communities. Is that money making a difference (Ginsberg, 2001)? Using program evaluation, this study attempted to determine if Deeper Love made a difference and achieved its intended outcome. The findings can assist to inform the program so that it becomes more effective. The results can provide valuable information to the agency and other agencies to intervene in the AIDS epidemic within the African-American community.

The Program

Deeper Love was developed in 1995 by AID Atlanta. The program was developed to address the issue of HIV/AIDS as it affects African-American men. Deeper Love is funded through the Center of Disease Control and Prevention and a private foundation called Health First. The participants are primarily recruited through word of

mouth, although the program advertises through local publications, staff presentations, various community forums, and referrals from AID Atlanta. Most of the outreach is done by volunteers who have participated in the program. Typically, there are 10-15 participants in each weekly session (Ehrmann, 2001).

Deeper Love is a 5-week risk reduction workshop for African-American MSM. The program is designed to provide useful tools that will aid participants in reducing their risk for HIV and other STD's. The mission of the program is to provide a safe space for African-American MSM to congregate, to discuss, to learn and to put into immediate practice positive behavior, based on new or revisited self-awareness and new or revisited knowledge. Deeper Love also provides continued support of the desired behavior change with follow up activities (Deeper Love Program, 1999).

The curriculum of Deeper Love consists of 5 sessions that are addressed over a 5-week period. Session 1, "Starting with Community," is oriented towards discussing the social identity of black men who have sex with men. It discusses the expectations that the black community may have from heterosexual men and gay men. It evaluates with the participants if there is a black lesbian and gay community. This module explores the various roles that may exist within the gay and bi-sexual community. In addition, the session questions how black MSM can get their needs met within the community. It concludes with a dialog on the effects of racism, class elitism, and homophobia, that are discussed in terms of its effects on the self-image and sense of community among gay men.

Session 2, "Going to the Source," examines personal beliefs and behaviors, and how they influence our histories as individuals within the society. This session works with the individuals on empowerment and personal responsibility. It explores personal goals and how behavior relates to achieving goals. The module concludes with a description of the labels that come with being a black gay or bisexual male and a discussion of the feelings attached to these labels.

Session 3, "Relationships-One-on-One," examines the types of relationships the participants want and the type of relationships that they are involved in. The session questions individuals about their expectations, communications, and behaviors. The session is designed to help participants learn to negotiate their relationships and increase self-awareness.

Session 4, "Sex and Risk," the goal of this session is to create a positive view of black MSM, increase or reinforce knowledge about HIV transmission and safer sex practices, and encourage healthy sexual activities. The module teaches good sexual behaviors (i.e. risk reduction). The workshop provides information on the impact of HIV/AIDS in the African-American community. It explores how the epidemic may have an impact on the individual, why so many gay men are being infected, and what individual's can do to prevent the spread of the infection.

Session 5, "Management and Negotiation," reinforces personal responsibility and empowerment. It provides information on sexual triggers that can interfere with practicing consistent safe sex. The session is designed to help participants develop skills in identifying and managing sexual triggers. These triggers guide individuals in making

sexual decisions. The session also teaches the participants problem solving skills in making better decisions. The topic explores communication with partners and addresses the topic of disclosure, especially as it relates to disclosing HIV status. The session concludes with a discussion on how to overcome negative thinking and fostering a healthy sense of self-esteem and fulfillment.

Statement of the Problem

It seems there are few programs that want to build a cogent, effective response to the HIV pandemic that resonates with young black men who are sexually active with other men. Many of the large AIDS service organizations, the ones that receive large shares of the AIDS prevention dollars have reacted to the criticism in a defensive manner. They state the problem as being related to black homophobia, and that black men need to "come out." AIDS organizations should not face blame for the prevalence and incidence of HIV among black men; however, these organizations do collect millions of dollars to prevent HIV transmission. There are two choices: (1) Either HIV prevention efforts should be supported and providers held accountable or (2) they are irrelevant and should not be supported and providers not held responsible for HIV prevalence or incidence (Wilson, 2001).

Significance of Evaluation

There have not been many interventions developed for black MSM evaluated in the literature. The significance of this evaluation is to assess if the program is effective and to provide further literature on how to best meet the needs of the target population.

The study is also significant to the field of social work, providing useful information on working with disadvantaged populations and helping to support programs that reward clients.

Summary

It is critical to examine the effectiveness of HIV/AIDS prevention programs that serve African-American MSM. This population faces an array of issues that hamper their ability to seek services and treatment. The efficacy of these programs becomes important in combating the spread and prevention of the AIDS epidemic. There needs to be an increase in the literature of data reflecting the personal experiences of men who have sex with men of color and the interventions that are beneficial. These programs need to be held accountable for program goals and program outcomes. The evaluation seeks to determine if the activities of the program are helping to change the desired behavior of the client. The following chapters outline the literature on MSM, specifically African-American men, the methodology in the evaluation, the results, the conclusions, and the implications for social work.

CHAPTER TWO

REVIEW OF THE LITERATURE

The literature review provides an overview of the devastating impact that HIV/AIDS has had on men who have sex with men, and especially African-American men. The literature presents behaviors that identifies this population to be at high risk for HIV infection. Prevention efforts that are shown to be effective for MSM and the changes that must be implemented to address the needs of African Americans within the target population is also discussed. Finally, the literature presents background information on the topic of men who have sex with men and the challenges HIV prevention programs face in responding to this epidemic.

Men Who Have Sex With Men (MSM)

There are an estimated 325,000 to 475,000 gay and bisexual men living with HIV in the United States. One hundred and forty-five thousand men were living with AIDS as of 1999. The June 2000 Center for Disease Control HIV/AIDS surveillance data identified MSM accounting for 56 percent of all adolescents and adults diagnosed with AIDS. If men who have sex with men through other modes of transmission (injection drugs, hemophilia, heterosexual contact, etc.) were included, they would compromise an absolute majority of almost 64 percent (Ehrmann, 2001.)

Men who have sex with men have been hit hard by the AIDS epidemic. In 1990, men who had sex with men accounted for 73.2 percent of AIDS cases; however this declined to 68.7 percent in 1994. Most of the decline occurred in white men who have sex with men, whose percentages declined from 51.2 percent to 45.5 percent. No such declines were observed for African-American, Asian-American, or Native-American MSM. Men of color are disproportionately affected by the HIV epidemic. The gay community is struggling with the fact that AIDS is here to stay, and that the prospect of a cure is far away. Overwhelming psychological, cultural, and spiritual issues surrounding living in the midst of an epidemic often overcome the ability or desire to remain uninfected (DeCarlo, 2000).

MSM are not a single homogenous group, but represent a variety of people, lifestyles, and health needs. From middle class gay men, to homeless runaways, to injection drug users, to incarcerated men, these men have different identities and associated risks for HIV and other infectious diseases. MSM refers to any man who has sex with a man, whether he identifies himself as gay, bisexual or heterosexual. In the U.S. society, men are pressured to show their manhood through sexual activity and aggressiveness. Given this, many MSM face additional challenges learning about dating, intimacy, sexual desire and love, as well as alcohol and recreational drug uses, homophobia, abuse and coercion, racism and self-esteem (Crosby & DeCarlo, 2000).

African-American Men Who Have Sex With Men

The continuing, widespread stigmatization of people of color creates enormous difficulty for combating the HIV/AIDS epidemic. Perhaps the greatest difficulty is that communities of color fear that stigmatization and discrimination are likely to increase as the public becomes aware of the disproportionate number of people of color who are infected with HIV.

The first report of AIDS in an African-American man was made in June 1981. By August 1981, one in nine of the reported homosexual males with AIDS were African-American. In 1982 African Americans and Hispanics/Latinos accounted for just under half of the males, more than three-fourths of the females, and almost two-thirds of the children who have been diagnosed with AIDS in the United States. African-American and Hispanic/Latino men with AIDS have comprised between 30 percent and 40 percent of all AIDS cases among adult and adolescent men. In 1989, the age-adjusted HIV-related death rate among African-American males was three times that of white males. Accordingly, the years of potential life lost per 100,00 population due to HIV, was 177 percent higher for African-American males than was the case for white males (National Commission on AIDS, 1992).

Two recent CDC funded studies underscore the need for action for African-American MSM. The first, a seven-city study of men who have sex with men, aged 15 to 22, conducted between 1994 and 1998, found that 14.1 percent of African-American participants tested positive for HIV, compared to 6.9 of Latinos and 3.3 of Caucasians. The second, a six city study of MSM, aged 23 to 29, conducted between 1998 and 2000,

found that 30 percent of African-American participants had HIV, compared to 15 percent of Latinos and 7 percent of Caucasians. The data from the studies show that annual infection rates are sharply higher among African-American men. There is more of a stigma in African-American and Latino communities about MSM. It is sort of like an underground world where these men have sex with men, then go home to their wives and girlfriends (Garbo, 2001).

Of the reported AIDS in black Americans, 81 percent involved males, 44 percent were exposed through homosexual or bisexual contact (Icard, Schilling, El-Bassel, & Young, 1992). Nearly a third of black men, who are gay or bisexual, have HIV before the age of 30. Black MSM learn early not to talk about their problems, seek care, get tested for HIV, or to disclose their HIV status. Some are shamed into silence even as they stay married, putting their wives and children, as well as their male sex partners, at risk (Wilson, 2001).

Risk Behaviors of MSM

Gay and bisexual men of all races remain at alarming risk for AIDS. In fact, the risk may again be increasing in some communities, as evidenced by recent outbreaks of sexually transmitted diseases, particularly gonorrhea and syphilis, among men who have sex with men. Prevention challenges include risk reduction, burn out among older men who have sex with men, mistaken beliefs that HIV is no longer a serious disease, a new generation of young gay and bisexual men, and the unique cultural issues men who have sex with men of color face regarding their race/ethnicity, as well as their sexual

orientation. A study by CDC scientists, of 1,942 HIV-infected gay and bisexual men, found that a growing percentage of MSM engaged in unprotected anal intercourse. The percentage of men who had unprotected anal intercourse during the previous 12 months rose from 13 percent in 1995-1996 to 19 percent in 1997-1998, an increase of nearly 50 percent. HIV-infected men who have sex with men were more likely to have multiple partners, use injection drugs, or crack cocaine, and have fewer than 12 years of education (Denning, Nakashima, & Wortley, 2000).

Penetrative anal sex frequently occurs in sex between men. If HIV is present in the insertive partner, and if condoms are not used, then anal sex carries an especially high risk of HIV transmission for the receptive partner. There is also a risk of HIV infection from unprotected anal intercourse, though a lesser one, for the insertive partner. The presence of other untreated sexually transmitted diseases can further greatly increase the risk of HIV transmission. Oral sex is also common among men who have sex with men. While HIV could be transmitted through such sex if not protected by a condom, the risk is generally considered low. In countries where HIV education emphasizes heterosexual transmission, men may be ignorant of the risks of male-to-male sex, or consider that the risks do not apply to them and may therefore be less likely to protect themselves. Many men who have sex with men engage in casual, fleeting and anonymous sexual encounters. Worldwide, a large percentage of these men are married, or have sex with women as well (UNAIDS, 2000).

In San Francisco, data from annual behavioral surveys among MSM and from the sexually transmitted disease surveillance program were analyzed to characterize certain

HIV risk behaviors of MSM and changes in incidence of male rectal gonorrhea among men who have sex with men. The proportion of surveyed MSM who reported having had anal sex increased from 57.6 percent in 1994 to 61.2 percent in 1997. Among MSM who had anal sex, the use of condoms declined from 69.6 percent in 1994 to 60.8 percent in 1997. The most declined use of condoms occurred among men aged 26-29 years. The proportion of men reported having multiple sex partners and unprotected anal intercourse, increased from 23.6 percent in 1994 to 33.3 percent in 1997. Decreasing consistent condom use and unprotected anal intercourse with multiple partners occurred in all racial/ethnic groups (Morbidity and Mortality Weekly Report, 2002).

Multiple sex partners, unprotected anal sex, and the hidden nature of MSM sexual relations in many communities, contributes to the prevalence of HIV among men who have sex with men. Many countries deny the existence of men who have sex with men. This denial and discrimination against these men feed the secrecy in which many men who have sex with men live, increasing their risk taking and making it difficult to reach them with HIV prevention interventions. Due to societal pressures, many men who have sex with men have both male and female partners, increasing the HIV risk for their female partners and decreasing the likelihood that men who have sex with men identify as men who have sex with men (Family Health International, 2002).

CDC identified other challenges that are presented within the HIV-prevention strategies among men who have sex with men. Research has demonstrated the difficulty of sustaining sexual behavior change over time in any population. Surveys of MSM found that some men make false assumptions about their partner's HIV status. With

more people living longer, healthier lives, as a result of antiretroviral therapy, there are increased opportunities for HIV transmission. There is a lack of motivation to practice safer sex in younger MSM who have never known anyone infected with HIV, or seen the toll of AIDS first-hand. Social and economic factors serve as barriers for receiving HIV-prevention services, particularly for men of color. The role of substance abuse in HIV transmission continues to be popular among some MSM (CDC, 2001).

Research has shown that while most gay men have protected sex all or most of the time, a significant percentage of MSM, as many as one in three, have some incidence of unprotected sex. The reasons for and context of this unprotected sex, and perceived risk for HIV involved in it, vary widely. Studies show some gay men engage in unprotected sex when they believe themself to be of the same serostatus of their partner. In addition, a wide variety of psychosocial factors influence the sexual risk taking among them: self-esteem, social supports or lack thereof, mood prior to sexual encounter, optimism, fatalism, age, education, and alcohol or drug use (Scout, 2001).

As of June 1995, a total of 31, 024 cases of acquired immunodeficiency syndrome had been reported among male infecting-drug users, who also reported sexual contact with other men. A study conducted from February 1991 through June 1994 analyzed MSM who were injection drug users (MSM IDUs). A total of 224 MSM IDUs had traded sex for money or drugs during the preceding 30 days. Almost all (95 percent) had more than one sex partner during the preceding 30 days. The mean number of sexual partners was 3.8 during the preceding 30 days. Most (89 percent) reported having one or more female sex partners. Nearly all (95 percent) had engaged in anal intercourse; 201

had anal intercourse with men and women, 51 with men only and 30 with women only. Eight of the 35 of the men with a main male partner and eight of 41 of those with a female main partner used a condom the last time they had anal intercourse with this partner. During the preceding 60 days, 250 of 292 MSM IDU's shared syringes or other paraphernalia used to prepare or inject illicit drugs (Morbidity and Mortality Weekly Report, 1995).

A number of factors may contribute to sexual risk taking among African-American men, such as nonmonogamy, unknown HIV status, perception of what "safe sex" is, and unprotected sex. Many African-American men have anxiety or fear about disclosing their HIV status, or negotiating risk behavior between their partners (Lifelong AIDS Alliance, 2002).

The incidence of HIV infection among young black men who have sex with men (BMSM) are among the highest of all risk groups in the United States. The data from CDC'S Young Men's Survey were used to evaluate the prevalence of unrecognized HIV infection, barriers to HIV testing, and reasons for nonuse of condoms among black men who have sex with men aged 15-22. There were 920 black men who had sex with men who participated. Of the 920 respondents, 150 tested positive for HIV. Of the 150 who tested HIV-positive, 139 were unaware of their HIV status and 58 perceived themselves at low risk for ever becoming infected. During the six months preceding the survey, 920 black men who had sex with men reported a median of two male sex partners, 712 reported having anal sex with another man, and 342 reported having unprotected anal intercourse. Of the 79 BMSM with unrecognized HIV infection who had unprotected

anal intercourse, 41 reported not using condoms for one or more of the following reasons: they knew they were HIV negative, they knew their partners were HIV negative, or they thought their partners were at low risk for infection. Of the 920 BMSM, 585 had ever tested previously for HIV, but few had test frequently. Of those that tested previously, 536 reported last testing HIV negative, and of these 87 were found to be HIV infected. The 332 men who had not tested previously, gave the following reasons for not testing: low risk for infection (45 percent), fear of learning the results (41 percent), and fear of needles (21 percent). Compared with their non-infected peers, young black men who have sex with men were more likely to engage in unprotected anal intercourse and not testing previously because of fear of learning the results (Morbidity and Mortality Weekly Report, 2002).

Prevention Programs and MSM

Over the years researchers and practitioners have studied a variety of HIV prevention approaches for men who have sex with men. HIV prevention programs for men who have sex with men have been hindered by the denial that sexual behavior between men takes place. The stigmatization or criminalization of men who engage in sex with other men also effects the success of these programs. Most programs have difficulties reaching the men of this population. In addition, there is inadequate or unreliable epidemiological information on HIV transmission through male-to-male sex (UNAIDS, 2000).

Many prevention interventions for gay and bisexual men have proven effective, as well as cost-saving over the years. The Center for Disease Control and Prevention has researched the programs that appear to work for the community of men who have sex with men. Peer opinion leaders have played a critical role in prevention for young men who have sex with men. The intervention involved popular opinion leaders trained to deliver AIDS risk-reduction messages to their peers who frequented gay bars. Three months later after the intervention, fewer gay men practiced unprotected sex. One component of community level intervention for young gay men, aged 18-29, used informal peer outreach and natural social networks to attract socially isolated men into safer educational activities. The intervention was successful in reducing rates of unprotected anal sex for participants. A program providing group counseling sessions on assertiveness training, behavioral self-management, and relationship-building skills for men who have sex with men resulted in less unprotected sex among participants (CDC, 1998).

HIV prevention programs using small group counseling, community outreach, community mobilization, stress reduction counseling, peer education, and skills training have been effective among all segments of men who have sex with men: men in epicenter cities, men in rural communities, young men, adolescents, men of color, and bisexual men (DeCarlo, 2001).

One successful approach to working with MSM has been to create or provide safe places where men can talk openly and receive sexually transmitted disease care and counseling. Such centers offer a space for men to gather, and may also operate male

sexual health projects with medical and psychosocial services, for men who have sex with men. Another successful approach is integrating safer sex education into existing social activities (Family Health International, 2002).

The first reality of HIV prevention is that it is working among white gay men (Burke, 2001). The level of AIDS cases among gay men continues to be unacceptable and the federal government must increase its focus on prevention and treatment efforts in communities of color. A lack of adequate resources for prevention efforts and an unparalleled stigma about homosexuality among men of color who have sex with men, is responsible for the spread and incidence of AIDS cases, according to reports by CDC. Also, the stigma may be a component in the early age at which gay and bisexual men become infected. Communities of color have not received equitable levels of access to treatment and care due to socioeconomic factors. With limited or no access to care and treatment, gay men of color develop AIDS much more rapidly and in higher numbers than members of other communities (CDC, 2000).

Among African-American gay men, a major obstacle to successful HIV prevention programs is the homophobia of many black community leaders and the lack of a well-organized, visible gay community of color, endowed with the capacity to lobby successfully for resources to support these programs. There have been few programs targeted to specifically address the needs of gay African-American men (Fullilove & Fullilove, 1998).

The Centers for Disease Control released a report indicating that blacks and Latinos make up the majority of AIDS cases among gay men. Since that time, AIDS

activists and educators have reevaluated their approach within the black gay population. Several outreach programs have been developed to provide support for black gay men and to provide education in regards to their position in the black community and the incidence of HIV/AIDS within this population. Four of the organizations noted as the leaders in the crusade to conquer efforts across the epidemic are: Us Helping US, Deeper Love, Brothers United, and New York's Gay Men of African descent. The programs provide condom distribution, support and discussion groups, holistic health seminars, HIV case management, HIV risk reduction workshops, a national toll free help line, and short- term therapy. The programs acknowledge that telling men to use condoms in not the only step towards prevention and focuses on education through empowerment and education (Williams, 2000).

Comprehensive, culturally appropriate and sensitive prevention and intervention programs must be designed to adequately address the needs of African-American MSM. The Men of Color AIDS Project was developed to address prevention needs of African-American men who have sex with men. During October 1999 to October 2000, 4,556 men who have sex with men received a series of HIV prevention interventions. Twenty-nine individuals were trained as peer educators, utilizing a culturally appropriate curriculum. Peer educators reached 651 individuals within their existing social networks and through venue based outreach. Venue based outreach, targeting African-American men who have sex with men, at two local bars reached 1,069 individuals. Street outreach to commercial sex workers and at risk youth of the population impacted 1,024 individuals. Through implementation of safer sex skits in two men who have sex with

men bars, 1,272 individuals were reached. The findings indicated that comprehensive prevention programs, utilizing multiple interventions, have a greater capacity to reach more individuals within the community of black MSM (Swayzer, 2001). It is also important to understand the support networks of these men that influence their decision making skills and the lifestyle.

The Support Networks and MSM

In recent years, researchers have paid more attention to the influences that family, peers, and community have on an individual's risk behavior. Several studies revealed strong relationships between an individual's sexual risk behavior and his or her perception of the support and norms within the social network. It was found that extreme isolation exists for many African-American gay and bisexual men and results in the internalized repression of their gay sexual identity. African-American MSM are less likely than white men to be involved in mainstream gay culture. These men lack access to institutions and social resources. African Americans continue to view HIV disease as a less concern than other public health issues, such as violence and drug abuse. The efforts to involve African Americans and African-American men to participate in HIV prevention programs are often received unenthusiastically.

The black church has long influenced the values within the African-American community. African-American gay and bisexual men see the black church as a major supporter of anti-gay attitudes. African-American men who have sex with men internalize these negative beliefs and, in turn, their sexual behavior is affected. A

number of African-American, gay-oriented, self-help organizations have emerged in response to AIDS and to provide support. In addition, black gay churches are emerging nationwide (Icard & Goodwin, 2000).

According to Ingram et al. (1999), numerous studies have focused on the positive social support of people living with AIDS. Researchers have focused little attention as to the nature and the effects of negative social interactions in this population. Ninety-six HIV-positive individuals were examined, 90 percent who were male. The participants reported relatively low levels of unsupportive social interactions. The rate of depression was 20.51, which is considerably higher than the general population. Individuals who reported more unsupportive interactions reported, higher levels of depression. Both the number of people in the person's support system and the level of satisfaction with the support system were associated with depression. Negative affectivity was strongly correlated with both depression and unsupportive interactions (Ingram, Jones, Fass, Neidig, & Song, 1999).

Support groups offer individuals living with HIV/AIDS a means of addressing the stressors associated with the illness. A study of 34 HIV-positive persons who attended support groups and 29 HIV-positive persons who did not attend support groups were examined. There was a tendency for men to attend support groups more than women. Persons who did not attend support groups reported lower self-esteem, greater cognitive depression, and greater somatic depression, anxiety, and loneliness than those who attended groups. Individuals who did not attend groups endorsed avoidant coping strategies than their counterparts (Kalichman & Sikkema, 1996).

Families can be detrimental in deterring the spread of HIV/AIDS and they can serve as a critical role in helping infected members deal with the illness. For each individual that is infected with HIV/AIDS there is a friend, parent, sibling, aunt, uncle, child, and partner who are also affected. Historically, scientists have used an individual perspective to examine the illness, which has often ignored the social context of the disease. Social isolation and burden may result from the stigma associated with HIV infection, a possible high-risk lifestyle, real or perceived rejection from family and friends, desire to remain anonymous, and not knowing whom to seek disclosure. The presence of the family support enhances the individual's ability to cope with physical and psychological stressors (Pequegnat & Bray, 1997).

Strengths and Weaknesses of the Literature

The literature provides an understanding of the impact that HIV/AIDS has on the population of men who have sex with men. It encourages further research and funding of HIV prevention programs of populations at risk and minority groups. The limitations of the literature are due to limited research on African-American men, African-American MSM, and studies compromised largely of white males. The literature fails to present a clear picture of the factors that influence African-American gay and bisexual men. The literature presents several factors, but no evidence of a study to support the information provided. There have been few studies conducted on African-American MSM, but due to the diversity of the population and the secrecy, the sample is often not representative of the greater population.

Proposed Evaluation

The proposed evaluation is an assessment outcome of Deeper Love of AID Atlanta. The evaluation is to examine the effectiveness of the program in meeting its desired behavior change and knowledge outcomes in African-American men who have sex with men. The primary questions are: Did Deeper Love increase HIV knowledge of participants? and (2) Did Deeper Love reduce the risky sexual behavior of workshop participants?

Conceptual Framework

The program evaluation is based on the AIDS Risk-Reduction Model and the Modified AIDS Risk Reduction Model. The model integrates elements of the Health Belief Model and the Transtheoretical model to explain AIDS preventive actions. It acknowledges behavior change as a multi-step process, with different psychological and social determinants at each stage. The model was originally designed to predict sexual risk reduction and can also be modified to predict drug-related risk reduction. Important factors are: (1) knowledge of risk levels of sexual activities and ways to make low-risk behaviors more desirable; (2) perceptions of HIV risk susceptibility; (3) perceived cost-benefits of reduced high-risk behavior; (4) self-efficacy beliefs; (5) emotional states; and (6) social factors including group norms, social support, help-seeking, and communication skills. The AIDS Risk-Reduction model emphasizes the roles of help-seeking behavior and aversive emotions in the enactment of safer sex practices. The model views behavior change in three stages: labeling of high-risk behavior, commitment

to changing high-risk behavior, and enactment of risk-reduction behavior. The movement from one stage to another stage is predicated upon achieving the goals and objectives of the prior stage. Emotions, alcohol and drug use, and environmental cues, impact behavior motivation over time. The model has been applied to gay men, but is also applicable to diverse populations (Mantell, DiVittis, & Auerbach, 1997).

The Modified AIDS Risk-Reduction Model posits that there are different determinants for each stage of behavior change because of the complexity of sexual risk behavior. The labeling stage of the AIDS Risk-Reduction model has been renamed the susceptibility stage. Determinants of this stage include knowledge of HIV transmission, sexual relationship factors, norms, and risk characteristics of self and partners. The AIDS Risk-Reduction Stage Commitment has been renamed the Intention Stage. Stage Determinants are quality of relationship, prevention methods, gender scripts, and peer norms. The Enactment Stage is retained in the Modified Risk-Reduction Model. The Stage Determinants consider sexual negotiation, sexual behavior, sexual functioning, and sexual efficacy as important factors. Two new stages have been added: Prioritizing and Maintenance. The Prioritizing Stage acknowledges the need to see prevention as important to competing the issues of life. The Maintenance Stage addresses long-term behavior change and the determinants include long-term cognitive beliefs, modified sexual behavior, and influence of peer norms for maintenance over time (Mantell, DiVittis, & Auerbach, 1997).

AIDS Risk Reduction closely reflects the goals of Deeper Love. The program provides knowledge of HIV/AIDS, explores the sexual factors that exist within the

relationships, and risk characteristics of self and partners. The program uses role-playing to discuss various roles, gender scripts, and norms within the African-American gay and bisexual community. The Deeper Love workshop addresses environmental and personal issues that the population is challenged and confronted by (multiple life stresses). Sexual triggers are explained and evaluated to address long-term cognitive beliefs, modify sexual behavior, and the influence of peers in behavior change. The workshop provides safe sex demonstrations of condom use and factors influencing disclosure to promote communication and negotiation with partners. The model describes the activities of the program to promote risk-reduction and increase the knowledge of HIV/AIDS.

Overall, the literature presents the risk of MSM, especially MSM of color. MSM continue to engage in risky sexual behaviors. Research has demonstrated the difficulty of sustaining sexual behavior change in any population. MSM make false assumptions about their partners and there is a lack of motivation for practicing safe sex. In addition, social and economic factors serve as barriers to MSM receiving effective HIV/AIDS prevention and education; particularly African-American MSM. Comprehensive culturally appropriate programs must be designed to meet the needs of African-American MSM. The evaluation examined the efficacy of a program tailored to meet the needs of the population and its overall efficacy. The following chapter presents the methodology of the evaluation to determine the effectiveness of Deeper Love.

CHAPTER THREE

THE METHODOLOGY

This section outlines the goals, objectives, and measures used to assess the efficacy of Deeper Love. There were two program objectives indicated for the 2000 - 2002 grant year. These objectives can be broadly classified under the following headings: (1) Increasing HIV/AIDS knowledge and (2) Reducing Risky Sexual Behavior of African American MSM. A Logic Model[1] was used to identify the most appropriate data sources to measure if the program met its goals.

[1] The Logic Model as defined here is based on the Theory Change which links program goals, purpose, objectives, activities, and methods of verification. Additional assumptions are used to help identify possible barriers that can be addressed over time.

Table 1

The Logic Model for Increasing HIV Knowledge

OBJECTIVE	INDICATOR	MEANS OF VERIFICATION	ASSUMPTIONS
GOAL: Increase HIV/AIDS knowledge among African American MSM (MSM)	Increased knowledge of HIV/AIDS	• Pre/Post tests of HIV/AIDS knowledge	• Participants respond honestly to the measures.
PURPOSE: Educate participants on HIV and AIDS	• Curriculum • Sessions	• A Deeper Love Curriculum • Assessment of curriculum • Process related assessments of the workshops	Curriculum effectively educates participants about HIV and AIDS
RESULTS: Increase HIV and AIDS knowledge among program participants	Increased post test knowledge scores	• Participant post-test knowledge scores	• Participants gained knowledge of HIV and AIDS • Increased knowledge is the result of Deeper Love alone.
ACTIVITIES: Workshop Pre/Post tests & Follow-up	Number of Sessions	• Participants attendance sheets • Facilitator logs (hrs worked)	• All documentation is reliable and valid • Participants attend and complete workshop

Table 2

Logic Model for Reducing Risky Sexual Behavior (RSB)

OBJECTIVE	INDICATOR	MEANS OF VERIFICATION	ASSUMPTIONS
GOAL: Reduce the Risky Sexual Behavior (RSB) MSM	Number RSB acts committed after participating in Deeper Love	• RSB rates pre/post-tests • RSB rates on the 3 month follow-up survey's	• Workshops will decrease RSB • Change can be adequately assessed within 3 months of completing the program
PURPOSE: Reduce the spread of HIV among the workshop participants	HIV/AIDS rate does not increase among the workshop participants.	• HIV status of participants following at pre/post, and 3 month follow-up	• Participants know their HIV status • Participants report their HIV status honestly.
RESULT: Increased sexual protection (SP) among workshop participants.	Number of SP acts committed.	• SP rates pre/post • SP rates @ 3 month follow-up	• SP acts are reported honestly among workshop participants
ACTIVITIES: Evaluate RSB pre/ post workshop and 3 month follow-up	Completed pre/post tests and 3 month follow-up survey's.	• Completed pre/ post tests • Completed curriculum assessments • Completed 3 month follow-up surveys	• Documentation is reliable and valid. • Participants can be tracked from pre test to 3 month follow-up

The Data Sources:

- Existing data sources: pre/post test, 3-month follow-up survey, and workshop satisfaction survey.
- Created data sources: facilitator interview.
- Missing data sources: process related data (logs of facilitator time, participant attendance sheets).

Existing Data Sources

The evaluation used the following existing measures: Questionnaire 1 and 2; A Workshop Satisfaction Survey; and the 3-month follow-up survey. Questionnaire 1 has 6 sections with a total of 47 questions with a multiple response format, including Likert-type response, True/False and multiple choice. The measure contains questions on personal beliefs about the participants' sexual behaviors, condom usage, knowledge of HIV/AIDS, sexual behaviors, and risk taking behaviors. Questionnaire 2 is a revised baseline measure. This measure pre-test was first implemented early in 2002. Additional content was added on HIV knowledge, behaviors used to avoid contracting HIV, HIV test taking history, and history of unsafe sexual activities.

The Workshop Satisfaction Survey measures the participants' contentment with the Deeper Love workshop. The survey has a 5-point Likert scale with a response format ranging from strongly agree to strongly disagree. There are a total of 22 questions and 3 sections. Section 1 pertains to the overall setting and time frame of the workshop. Section 2 assesses the participants' perception of the workshop. Finally, section 3 is a self-evaluation of the workshop. The surveys are completed during the fifth session of the workshop.

The 3-month follow up is designed to assess the participants' ability to implement the information they learned in the workshop and ultimately reduce their risk of contracting (or spreading) HIV. The survey has two sections: Section 1 assesses HIV/AIDS knowledge, transmission, treatment options, and the Georgia laws regarding HIV and AIDS self-disclosure. Section 2 assesses risky sexual behavior practices, behavior with 'new' sexual partners, HIV test taking history, types of sexual acts engaged in, condom usage, and behaviors and attitudes during the unsafe practices.

Setting

The evaluation took place at AID Atlanta, which is located in downtown Atlanta, Georgia. AID Atlanta is one of the most comprehensive programs providing services to the patients and families who have been affected by the AIDS epidemic.

Sample

The study includes data collected from African-American MSM who participated in Deeper Love between 2000 and 2002. The sample includes 31 African-American MSM, who are 18 years of age and older, and who completed the 5-week workshop. Participants must have attended all 5 sessions on a consistent basis and must be fluent in English.

Design

The design of the program evaluation is O_1 X O_2 O_3 O_4. "O_1" represents the pretest given at the initial session of the Deeper Love Program. "X" represents the intervention

(activities) provided by Deeper Love. "O_2" represents the satisfaction scales administered at the completion of the program. "O_3" represents the 3-month follow up conducted for participants after completion of the program. "O_4" represents the interviews conducted of the facilitators. The data were compared across the time span to evaluate the effectiveness of the program over the last 3 years. The design used is the best for examining the immediate effect of the program. The external validity threats to this program evaluation are maturation of participants, passage of time, and the difference of facilitator in providing information.

Procedures

The data for the evaluation was collected between October and November 2002. The evaluation team met with both the facilitator and director of Deeper Love. In this meeting the evaluation team was given detailed information on the purpose, development, and implementation of the program. In addition, data collected between 2000-2002 were given to the evaluation team. The data were sorted according to the month and year the participant completed the program.

Interviews were conducted with the facilitators of the program at AID Atlanta. The interviews took place in the facilitators' office on November 5, 2002. The facilitators were provided with a copy of the interview questions prior to the interview. The interview contained nine open-ended questions which allowed them to respond to the questions in their own way.

Data Analysis

After collecting the data, the evaluation team used descriptive statistical analysis to provide a concise summary of the data. Simple frequency tables and bar graphs were used to display the results. Finally, relevant responses from the interview were integrated to interpret the data.

Summary

This section provided a clear descriptive picture of how the data were collected, analyzed, and explained, using descriptive analysis to present the data in simple terms. The data are analyzed according to the available completed instruments. The design would have been more effective if there were more information available. The statistical program allows for each variable to be analyzed and compared. It provided a clear picture of the mean, mode, and frequency of the variables. The data illustrate the satisfaction of the program participants and the perception of the program effectiveness by the facilitators.

CHAPTER FOUR

THE FINDINGS

The information in this section is presented in four sections. Section I outlines the demographics of the sample population. Sections II and III present the data that corresponds to the evaluation questions: (1) Did Deeper Love increase the HIV knowledge of the workshop participants? and (2) Did Deeper Love reduce the Risky Sexual Behavior of workshop participants? Finally, Section IV provides information on issues related to the implementation of the program.

Section I: The Demographics

The evaluation included data on 31 African-American male participants who reported having sex with other men and who completed the workshop (Table 3). The participants attended Deeper Love between 2000 and 2002. There were 5 participants in 2000, 10 participants in 2001, and 16 participants in 2002. Twenty-two of the participants reported to be HIV-negative, 5 HIV-positive, and 4 provided no response. While all participants must be over 18 years old to attend the workshop, an average age cannot be computed due to inconsistent responses to this question.

Table 3

Participant Demographics (N=31).

Demographics	**2000**	**2001**	**2002**
	(n=5)	**(n=10)**	**(n=16)**
Ethnicity			
African American	100%	100%	100%
Age			
Unknown	--	--	--
HIV Status:			
Positive	0	2	3
Negative	4	7	11
Unknown	1	1	2

Section II: Did Deeper Love Increase HIV Knowledge Among African-American MSM?

As evidenced by the number of questions answered correctly (see Tables 4 and 5, pages 35 and 36, respectively) the participants began Deeper Love with a high level of HIV knowledge.

Table 4

HIV Knowledge (N=15- Questionnaire 1)

Variable	N	Percentage
Reduced partners will protect from you from AIDS		
True	4	26.7%
False*	11	73.3%
A cure for AIDS is expected		
True	1	6.7%
False*	14	93.3%
A positive result can occur from people who do not carry the virus		
True*	9	60.0%
False	5	33.9%
	1 (missing)	6.7%
A great deal is known about AIDS		
True*	12	80.0%
False	2	13.3%
	1 (missing)	6.7%
Condoms make intercourse completely safe		
True	1	6.7%
False*	14	93.3%
Oral sex is safe if partners do not swallow		
True	2	13.3%
False*	13	86.7%

*indicates correct answer

Table 5

HIV Knowledge (N=16-Questionnaire 2)

Variable	N	Percentage
HIV infection/ person can still test negative		
True*	15	93.8%
False	1	6.3%
HIV infectious/ high concentration (blood)		
True*	16	100.0%
False	0	
HIV infectious/ high concentration (semen)		
True*	16	100.0%
False	0	
HIV infectious/ high concentration (saliva)		
True	5	31.3%
False*	11	68.8%
Once infected/ infected for life		
True*	15	93.8%
False	1	6.3%
Condoms offer 100% protection		
True	2	12.5%
False*	13	81.3%
	1 (missing)	6.3%
Oral sex can transmit HIV/STD's		
True*	16	100.0%
False	0	
Georgia law requires disclosure of HIV status		
True*	14	87.5%
False	2	12.5%

*indicates correct answer

As identified in the Logic Model (see Tables 1 and 2, pages 27 and 28, respectively), no outcome data on post-program knowledge was available for analysis (i.e., post-tests or curriculum-related surveys). Consequently, the question of knowledge gained as a result of participating in the program can not be answered. However, information on participant satisfaction with the program can be provided.

The Workshop Satisfaction Survey assessed the performance of Deeper Love facilitator(s). Overall, a majority of the participants (82 percent) felt the facilitator actively encouraged group participation, was knowledgeable (67 percent), and skilled (71 percent). As a result of attending the workshop:

- 35 percent of the participants felt they understood themselves better
- 39 percent felt better about themselves
- 42 percent felt they knew more about the transmission of HIV/STD's
- 57 percent felt they could use what they learned to improve their relationships with others
- 46 percent felt more empowered about the fight against the HIV epidemic
- 50 percent felt more aware of the barriers to HIV prevention in the African American MSM population, and
- 32 percent felt they knew more about activities and services for the African American MSM populations.

Section III: Does Deeper Love Reduce Risky Sexual Behavior Among African-American MSM?

The second objective of Deeper Love is to reduce Risky Sexual Behavior of African-American MSM. To address this question data from the 3-month follow-up survey was used. A total of 20 surveys serve as the basis for the following analysis and conclusions. Table 6 outlines the frequency with which participants engage in Risky Sexual Behavior.

Table 6

Risky Sexual Practices (N=20)

	Receptive Anal	Insertive Anal	Receptive Oral	Insertive Oral	Receptive Rimming	Insertive Rimming
Not w/in 6 months	40% (8)	50% (10)	30% (6)	25% (5)	45% (9)	45% (9)
Less than once a month	25% (5)	20% (4)	20% (4)	15% (3)	25% (5)	20% (4)
Once a month	15% (3)	15% (3)	30% (6)	35% (7)	15% (3)	15% (3)
Once a week	5% (1)	10% (2)	10% (2)	15% (3)	5% (1)	10% (2)
More than once a week	5% (1)	5% (1)	5% (1)	10% (2)	5% (1)	5% (1)
Missing	10% (2)	0	5% (1)	0	5% (1)	5% (1)

As evidenced by Table 6, on average participants still engage in Risky Sexual Behavior at fairly equal rates over the course of a week or month or longer. Figure 1 further illustrates that when participants do engage in Risky Sexual Behavior, a majority "never" wear condoms.

CONDOM USAGE

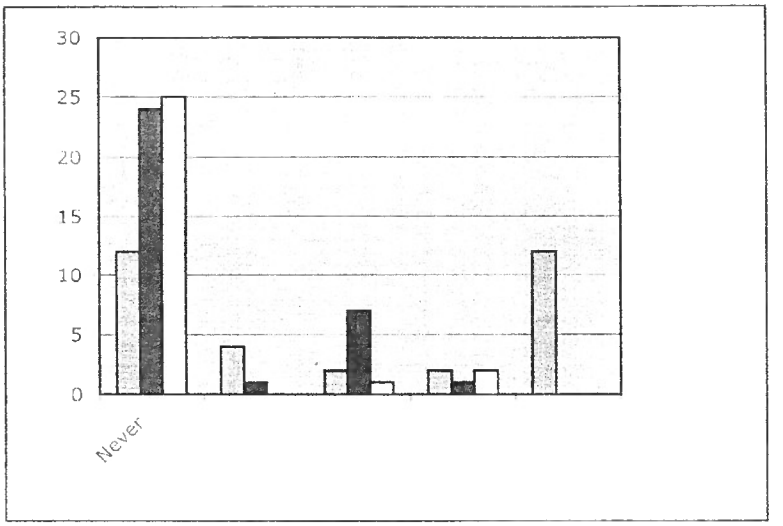

Figure 1: Frequency of condom usage among workshop participants 3 months following the program (N=20).

When asked about other prevention measures taken to reduce the spread of HIV/AIDS, again a majority of the respondents did not. However, those who did engage in some form of prevention, typically did so by reducing their number of sexual partners, did not ejaculate orally, engaged in less anal/oral sex, or avoided unsafe places (Figure 2).

PREVENTION MEASURES

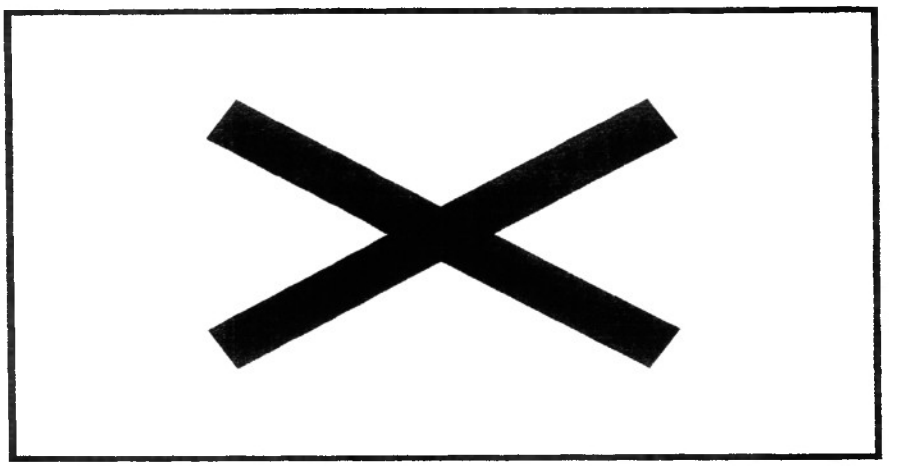

Figure 2: The type and frequency of prevention measure engaged in by participants 3 months following the program (N=20).

When asked why they continued to engage in "unsafe" sexual behavior, participants said:

- 100 percent - HIV (+) and monogamous
- 90-95 percent - safe sex was inconvenient; feared rejection by partner; they were unaware they were at risk; they were under the influence of drugs or alcohol; their partner was attractive
- 80-85 percent - They were aroused and didn't want to stop; they dislike condoms; they are uncomfortable asking their partner to practice safe sex; safe sex is unsatisfying; they don't know
- 65 percent - They are HIV (-) and monogamous.

Finally, places where respondents typically meet new sexual partners include: through friends (30 percent), at parties (25 percent), at gay social events (20 percent), and in internet/chat rooms (20 percent).

Section IV: Program Implementation

The following information was collected from interviews with the past and current Deeper Love coordinators. Overall, the facilitators felt the program was effective in meeting its goal, but they did note several challenges. They reported challenges in reaching the target population. The program recruits participants through networking, sending e-mails, and through personal contact. The program also makes condom packs with information included and gives them out during club and street outreach. Deeper Love also advertises at bookstores, the Gay and Lesbian Center, and various coffeehouses in metropolitan Atlanta. The program also tries outreach on college campuses by putting up fliers. However, the fliers have often not brought about the desired results to increase participation from college men who have sex with men.

Deeper Love is facilitated either in the AID Atlanta building or at the Atlanta Gay and Lesbian Center. The target population is described as comfortable and physically safe in either location. There does seem to be a stigma attached to coming into either facility because some participants have stated their discomfort with that.

Another recruitment challenge is in the area of hiring employees to implement the program. All employees of AID Atlanta are required to take a course called AIDS 101, which is a 1-day seminar. Individuals complete "specialized" training for certain

programs. In-service educational forums are also offered to staff. While educational experience is very important, the agency is not always stringent on that area. "Lived experience" with HIV/AIDS is considered an asset to working in the program.

Coordinators agreed that the Deeper Love clients are "very" satisfied with the program. Coordinators receive a lot of "immediate" and "personal" feedback from the workshop participants. Often participants want to attend the program more than once, or even desire to facilitate a group. There does seem to be improved communication among program participants.

CHAPTER FIVE

CONCLUSIONS

This chapter examined the outcome of the program evaluation, along with the findings relevant to the objectives and curriculum of the program. The data suggest that the participants enter the program with an increased level of HIV knowledge, that they continue to engage in sexual risky behavior, and that at the 3-month follow up continued to report to engage in sexual risky behavior.

The curriculum of the program is as follows: session 1, starting with the community; session 2, going to the source; session 3, relationships one-on-one; session 4, sex and risk; and session 5, management and negotiation. The questions within the measure are not linked to the significance of the program. For example, in session 1 the program questions how can black men who have sex with men get their needs met in the community, but there is no question within the measure to provide the answer. Session 2 explores how labels influence behavior. Once again, there are no questions within the measure to provide the information to the agency. The measure does not require participants to provide personal information regarding relationships, which is addressed in session 3. There are questions to measure the level of HIV/AIDS knowledge and the risky sexual behaviors discussed in session 4. The questionnaire includes questions that would provide information regarding the triggers that influence the practice of safe sex.

In examining the results and comparing the results to the curriculum, there are some interesting findings. Based on the baseline measure of the HIV knowledge, the population is aware of the risk and mode of transmission of HIV. The participants rated over a 70 percent average in the questions specific to HIV knowledge for all time frames. Over 80 percent of the population reported the correct statement that condoms do not offer 100 protection or make intercourse 100 percent safe. Overall, the participants have the knowledge of HIV. The program may need to consider only reinforcing their knowledge and focus more attention on risky sexual behavior.

In addition, the literature review provides information regarding the "down low" community of African American men who have sex with men. The program may want to explore how to integrate the topic within the curriculum. In addition, to include knowledge concerning the sexual practices with women that may also place the participants at risk for HIV.

The findings from the baseline of risky sexual behavior are important due to only one session, session 4 discussing sex and risk. Only 30 percent of the participants reported behavior at the baseline to not be at risk of HIV. Within the last month prior to their involvement of the workshop, 60 percent reported their behavior to not be at risk of HIV. Fifty-six respondents indicated multiple responses to implementing behaviors in the past six months to prevent HIV. Approximately 12.5 percent of the population reported one sex partner as a behavior to prevent HIV. What is interesting is that, 68.8 percent indicated being afraid that their partner would not have sex if they attempted to practice safe sex as a reason for unsafe, or possibly unsafe sex. These findings are

important in implementing changes within the program and possibly increasing the percentage of discussing sex and risk within each session. The participants are aware of the risk associated with HIV; however, 70 percent of the population within the last year placed themselves at risk and 40 percent within the last month.

The findings at the 3-month follow up also support the need to increase education on sex and risk. Fifty percent of the respondents reported that they had participated in receptive anal sex in the past 6 months, with less than once a month (25 percent) being the most common frequency. Seventy-five percent of the respondents reported they continue to engage in insertive oral sex once a month (35 percent) being the most common frequency. Thirty percent of the respondents reported that they always use condoms. However, in the receptive category, 35 percent of the respondents reported that they never used condoms in the past 6 months. In the insertive category 25 percent of respondents reported that they never used condoms in the past 6 months. In the oral sex category, 60 percent reported no condom use in the past 6 months, although, 95 percent of the respondents indicated that oral sex can transmit HIV. In the rimming categories (receptive and oral), approximately 60 percent reported that they never used condoms in the past 6 months when performing the sexual acts.

It may also be important to define "sex" within the measures. Ten percent of the respondents, at the 3-month follow-up, indicated that they have not had any sex in the past 6 months, while 100 percent reported that they had not stopped having oral sex. In addition, within the measures, the participants were asked to determine the sexual activities in the last 6 months that they consider unsafe or possibly unsafe. Sixty percent

(12) reported that yes, they had participated in unsafe sex in the last 6 months. Forty percent (8) reported that they had not. The idea of the perception of the behaviors that the participants consider safe or unsafe may also need to be explored further.

At the 3-month follow up, 80 percent indicated they did not know why they chose to participate in unsafe sexual practices. This is extremely different than the findings from the baseline; however, not able to make a comparison, due to not being able to identify the participants' pre-test with their follow-up results. Fifty-five percent of the respondents indicated having one partner being the behavior to prevent HIV. The curriculum should also address the risks associated with having one partner and still placing self at risk, if having unprotective sex or practicing risky sexual behaviors.

The findings from the interviews present the perspective of the facilitators' view of the effectiveness of the program. The facilitators felt the program was effective, based on their face-to-face contact with the participants and feedback provided. The documentation of that feedback or the collection of the data to support the positive feedback, is instrumental in concluding the effectiveness of the program. However, from the findings of the Satisfaction Scales, 82 percent of the participants felt encouraged from the facilitators of Deeper Love. Although, only 50 percent reported to be aware of the barriers to HIV prevention in the African-American men who have sex with men population. Also, 46 percent felt more empowered about the fight against HIV. The program may want to look into their policy of allowing participants to join after the workshop has began, 11 percent reported that they disliked the fact that new participants were able to come into the workshop during the middle of the session.

There are definitely challenges in collecting data from this population. The participants failed to provide answers to all questions, or provided different answers to questions worded differently, but obtaining the same information. The percentage of the participants who were HIV negative and HIV positive is not accurately reflective of the sample, due to some participants refusing to answer.

Based on the conceptual framework, the program implements various programs that are explained in the program description. The program does acknowledge that behavior change is a multi-step process, with different psychological and social determinants at each stage. The program does consider the factors involved to change behavior and have developed the questionnaires and the curriculum to increase HIV/AIDS knowledge and reduce risky sexual behavior (see Logic Model). The program does assess the level of knowledge of risk, the perception of HIV susceptibility, and self-efficacy beliefs through participant feedback and responses provided on the questionnaires. The program does not assess perceived cost-benefits of reduced high- risk behavior, nor does it explore in depth the emotional state of participants that are involved in the program.

CHAPTER SIX

RECOMMENDATIONS

The recommendations are based on the findings of the program evaluation. The recommendations take into account the strengths of the evaluation and the suggestions are for future program evaluations. The implications for social work are also presented.

Based on the data collected, the agency fulfills its objective in providing a safe space for the target population. The facilitators are viewed as competent and having knowledge of the topic. The participants express to feel better in regards to themselves and being able to make better decisions in regards to their sexual risk taking behavior. However, due to the clients continuing to report to engage in risky sexual behavior, or not being aware of the risks associated with certain sexual acts of this population, the agency may want to increase the percentage of information being provided regarding sex education.

The agency is effective in marketing the program and reaching the target population. However, the risky sexual behavior prevention methods may need to be formatted through social and party events, since this seems to be a common meeting place for meeting new sexual partners.

The clients are entering the program with the basic knowledge of HIV. The program may want to emphasize the mode of transmission, due to the participants' lack

of knowledge in this area. Specifically, the mode of transmission for this population, whether they are the receptive or insertive partner and the risk associated.

In order to provide a more accurate picture of the agency's effectiveness, the consistent collection of data is required. The agency can look into hiring or assigning an employee to collect the required pre-test, the post-test of the participants in each session, and developing a tracking system to identify each participant's measures (e.g., assigning a code number to each participant). Upon completion of each measure, the information will be entered into the system. Therefore, if the 3-month follow-ups are conducted, the agency can have baseline information to compare. The comparison will allow the agency to examine if there is change in the level of HIV knowledge and risky sexual behaviors. There should be structured management of the data collection. There are 9 to 10 sessions conducted during the year. In order for the program evaluation to provide accurate data, there should be 100 copies of each measure for each year evaluated.

The consistent data collection will provide the agency with valuable information and more importantly, the number of participants that the agency has reached. The data could also provide the number of participants who have implemented the positive behavior change, due to the agencies' intervention. The data collection could also help to provide more effective services to the specific population, in examining the needs of the population.

The agency appropriately assesses the baseline level of knowledge and risky sexual behaviors from the clients. However, in order to determine the effectiveness of the program, the collection of post-tests is required. The pre-test and the post-test should

be structured around the curriculum. The program will obtain more concrete information if the clients were assessed after each module. The measures should be linked to the curriculum. In addition, there should be a preface to explain to the participants the exact information the agency wants to obtain. Each question within the measure should be explained in how it relates to the curriculum and what will be measured.

The recommendations are to suggest changes that Deeper Love can implement within the program, in order to have stronger findings to suggest the effectiveness of the program. Overall, the program evaluation is not able to conclude the effectiveness of the program, due to the external validity threats of the program. The external validity threats to the program evaluation include: the lack of all completed pre-tests, post-tests, satisfaction scales, 3-month follow-up surveys. The data being collected over a 3-year time span, and no method to identify the participants' pre-test with any completed satisfaction scales, or 3-month follow up. As previously mentioned, the program is reaching the target population. It is the hope of the evaluators that the recommendations are beneficial to the agency. The agency provides a valuable and needed service to the African-American men who have sex with men population. If the agency is able to show their effectiveness, more services can be implemented in cities where required.

Program evaluation is an important tool that social workers must learn to utilize in evaluating programs and providing the most effective service to clients. Program evaluation provides valuable information to present the strengths and weaknesses of a program. It allows the program to analyze the structure of its services and provide data to present that the services are beneficial to clients. One of the main goals of the social

work profession is to empower the clients that we serve, there is no better way to empower them than by ensuring that the services are effective. The evaluation is conducted to present how important learning and utilizing program evaluation can help serve the specific population of interest and to improve the agencies and the services they provide. Social workers must make programs more accountable of their services and require documentation of how the service is beneficial. Social workers are responsible for ensuring that the services provided to the people are in deed helping and not hindering their full potential.

APPENDIX A

QUESTIONNAIRE 1

DEEPER LOVE WORKSHOP

-

Please Circle most appropriate answers: In The Past 6 Month

I have had (#'s) M___F___ (oral, anal, or vaginal partners).

1. I have had protected anal sex.
Always Sometimes N/A Seldom Never
2. I have protected oral sex.
Always Sometimes N/A Seldom Never
3. The use of condoms interferes with my sexual pleasure.
Always Sometimes N/A Seldom Never
4. Condoms ruin the mood.
Always Sometimes N/A Seldom Never
5. I feel in control or my sexual encounters.
Always Sometimes N/A Seldom Never
6. Has your personal self-esteem felt low.
Always Sometimes N/A Seldom Never
7. My sexual behavior has put me at risk for HIV/STD's.
Always Sometimes N/A Seldom Never
8. I feel comfortable discussing HIV with my sexual partner (s).
Always Sometimes N/A Seldom Never
9. I am able to effectively communicate my desires to my partner (s).
Always Sometimes N/A Seldom Never
10. I am aware of the attributes that I desire for my romantic relationship (s).
Always Sometimes N/A Seldom Never

For each question, please circle the appropriate number indicating the extreme to which you agree or disagree.

Strongly Disagree	Somewhat Disagree	Slightly Disagree	Slightly Agree	Somewhat Agree	Strongly Agree
1	2	3	4	5	6

APPENDIX A

(continued)

1. Using condoms are pleasurable.
1 2 3 4 5 6
2. I think condoms are an excellent means of protection.
1 2 3 4 5 6
3. Condoms are unreliable.
1 2 3 4 5 6
4. I feel confident that I can use a condom effectively.
1 2 3 4 5 6
5. I plan to use a condom every time I engage in sexual intercourse.
1 2 3 4 5 6

1. Condoms make intercourse completely safe.	T	F
2. Oral sex is safe if partners do not swallow.	T	F
3. By reducing the number of sexual partners, you are effectively protected from AIDS.	T	F
4. A cure for AIDS is expected within the next two years.	T	F
5. A positive result on the AIDS virus antibody test can occur even for people who do not carry the virus.	T	F
6. A great deal is now known about how the AIDS virus is transmitted.	T	F

Now, please answer the following with your best opinion about yourself by circling the response that describes you best.

1. Based on your behavior in the last year, what do you think is your risk for getting the HIV/AIDS virus?

No risk at all
Slightly at risk
Somewhat at risk
Good deal at risk
Great deal at risk
Extremely at risk

2. Based on your behavior in the past month, what do you think is your risk for getting the HIV/AIDS virus?

No risk at all
Slightly at risk
Somewhat at risk
Good deal at risk
Great deal at risk
Extremely at risk

APPENDIX A

(continued)

Using the scale for each, please rate how much risk you believe each of the following sexual behaviors is for transmitting HIV.

No risk	Low risk	Moderate risk	High risk	Very high risk
1	2	3	4	5

1. Anal sex without a condom until ejaculation-inserting your penis in your partner.
1 2 3 4 5
2. Anal sex without a condom until ejaculation-your partner inserts his penis in you.
1 2 3 4 5
3. Anal sex without a condom and withdrawing before ejaculating-inserting your penis in your partner.
1 2 3 4 5
4. Anal sex without a condom and withdrawing before ejaculating-your partner inserts his penis in you.
1 2 3 4 5
5. Anal intercourse with a condom - your partner inserts his penis in you.
1 2 3 4 5
6.Oral sex without a condom with ejaculating in your partner's mouth.
1 2 3 4 5
7. Oral sex without a condom with your partner inserting his penis and ejaculating in your mouth.
1 2 3 4 5
8. Deep Kissing
1 2 3 4 5
9. Oral sex with a condom-inserting your penis in your partner's mouth.
1 2 3 4 5
10. Oral sex with condom- your partner inserts his penis in your mouth.
1 2 3 4 5
11. Oral sex-partner licking your shaft or balls without putting his mouth on the penis head.
1 2 3 4 5
12. Oral sex-you lick your partner's shaft or balls without putting you mouth on the penis head.
1 2 3 4 5

APPENDIX A

(continued)

For each question, please circle the appropriate number indicating the extreme to which you agree or disagree.

Strongly Disagree	Somewhat Disagree	Slightly Disagree	Slightly Agree	Somewhat Agree	Strongly Agree
1	2	3	4	5	6

1. I came to this class to make new friends.
1 2 3 4 5 6
2. I came to this class to meet cute guys.
1 2 3 4 5 6
3. I came to this class to learn about what constitutes risky behaviors.
1 2 3 4 5 6
4. I am willing to alter the behaviors which put me at risk for HIV.
1 2 3 4 5 6
5. As a result of the Deeper Love workshop, I feel more empowered to make better decisions regarding my sexual practices.
1 2 3 4 5 6
6. As a result of the Deeper Love workshop, I feel more knowledgeable about the transmission of HIV.
1 2 3 4 5 6
7. As a result of the Deeper Love workshop, I feel more knowledgeable about the transmission of HIV.
1 2 3 4 5 6
8. I make good decisions.
1 2 3 4 5 6
9. It is easy for me to make new friends.
1 2 3 4 5 6
10. I was truthful in answering these questions.
1 2 3 4 5 6

Have you ever been told by a doctor or other health professional that you were infected with HIV or that you have AIDS. (Circle most appropriate answer)

Yes No Cannot Remember/Don't know Do not wish to respond

APPENDIX B

QUESTIONNAIRE 2

DEEPER LOVE

Please answer True (T) or False (F) for each of the following questions:

T	F	1. You can catch HIV from mosquitos.
T	F	2. Immediately after HIV infection, a person can test negative for HIV, but still be infected.
		3. HIV is found in high enough concentration to be infectious in the following:
T	F	a. Blood
T	F	b. Sweat
T	F	c. Semen
T	F	d. Breast Milk
T	F	e. Saliva
T	F	f. Vaginal secretions
T	F	4. Once infected with HIV, a person is infected for life.
T	F	5. If you are infected with HIV, you have AIDS.
T	F	6. All persons with HIV/AIDS will benefit from current drug treatments.
T	F	7. If used properly, condoms offer 100% protection against the transmission of HIV/STD's during sex.
T	F	8. Oral sex can transmit HIV/STD's.
T	F	9. There are many people infected with HIV who look healthy and feel well, but can transmit HIV to others.
T	F	10. The number of new HIV infections in the United States is declining.
T	F	11. By Georgia Law, a person living with HIV is required to share that information with any person they are having sex with.

12. Have you been tested for HIV (circle one)
    a. never tested
    b. tested once, within the last six months
    c. tested once, more than six months ago
    d. tested more than once, most recently within the last six months
    e. tested more than once, most recently more than six months agp

13. What was the result of your last HIV test?
    a. positive
    b. negative
    c. did not go back for the results

APPENDIX B

(continued)

14. In the past 6 months, which behaviors below indicate those you have tried in order to avoid HIV transmission? (check all that apply)
    - __I have had only one sex partner, and we both are monogamous.
    - __I have had sex with fewer partners.
    - __I have been more careful about choosing my sex partners.
    - __I no longer have sex when I'm drunk or high.
    - __I have avoid places where unsafe sex is likely to happen.
    - __I have had less anal sex.
    - __I haven't let my sex partner(s) cum in my ass.
    - __I have stopped having anal sex altogether.
    - __I have less oral sex.
    - __I haven't let my sex partner (s) cum in my mouth.
    - __I have used condoms when having oral sex.
    - __I have stopped having oral sex altogether.
    - __Other
    - __None of the above: I have not been sexually active in the last 6 months.

15. Have you participated in any sexual activities during the last 6 months that you consider unsafe or possibly unsafe.
    _____Yes _____No (skip question 16)

16. Which if any of the following do you think best describes why you had unsafe or possibly unsafe sex? (check all that apply)
    - ___No condom was available.
    - ___I was drunk or high.
    - ___Safer sex was not convenient.
    - ___Safer sex is not satisfying to me.
    - ___I was turned on and didn't want to stop what I was doing.
    - ___I don't like condoms.
    - ___I was not comfortable asking my partner to practice safer sex.
    - ___My partner was attractive.
    - ___I was afraid my partner would not have sex with me if I insisted on safer sex.
    - ___My partner and I are both HIV-negative, and we don't have sex with others.
    - ___My partner and I are both HIV-postive, and we don't have sex with others.
    - ___I didn't know at the time that it was risky behavior.
    - ___I know what the risk is, and I choose to take it.
    - ___I don't know the reasons.
    - ___Other

APPENDIX C

THREE-MONTH FOLLOW UP

Three Month Follow-Up

Deeper Love/Puppy Love Participant Follow-Up Questionnaire

Section 1: HIV Basic Information

Please answer True (T) or False (F) for each of the following questions:

T	F	1. You can catch HIV from mosquitos.
T	F	2. Immediately after HIV infection, a person can test negative for HIV, but still be infected.
		3. HIV is found in high enough concentration to be infectious in the following:
T	F	a. Blood
T	F	b. Sweat
T	F	c. Semen
T	F	d. Breast Milk
T	F	e. Saliva
T	F	f. Vaginal secretions
T	F	4. Once infected with HIV, a person is infected for life.
T	F	5. If you are infected with HIV, you have AIDS.
T	F	6. All persons with HIV/AIDS will benefit from current drug treatments.
T	F	7. If used properly, condoms offer 100% protection against the transmission of HIV/STD's during sex.
T	F	8. Oral sex can transmit HIV/STD's.
T	F	9. There are many people infected with HIV who look healthy and feel well, but can transmit HIV to others.
T	F	10. The number of new HIV infections in the United States is declining.
T	F	11. By Georgia Law, a person living with HIV is required to share that information with any person they are having sex with.

APPENDIX C

(continued)

Section 2: Behavioral History

12. Have you been tested for HIV (circle one)
    d. never tested
    e. tested once, within the last six months
    f. tested once, more than six months ago
    g. tested more than once, most recently within the last six months
    h. tested more than once, most recently more than six months agp

13. What was the result of your last HIV test?
    i. positive
    j. negative
    k. did not go back for the results

14. Below is a list of sex acts that some men do with other men. Please use the following scale to indicate the frequency of your participation in the listed behaviors on average during the past 6 months.
    1= Have not done in the last 6 months
    2= Less than once a month
    3= Once a month
    4= Once a week
    5= More than once a week

_____ Receptive Anal Sex/Fucking (a man puts his dick in your ass)
_____ Insertive Anal Sex/Fucking (you put your dick in another man's ass)
_____ Receptive Oral Sex/ Blowjob (a man puts his dick in your mouth)
_____ Insertive Oral Sex/Blowjob (you put your dick in another man's mouth)
_____ Receptive Anilingus/Rimming (a man puts his tongue on or in your anus)
_____ Insertive Anilingus/Rimming (you put your tongue on or in another man's ass)

15. If you have had anal or oral sex in the last six months, please use the following scale to indicate, on an average, how often you have used condoms or other latex barriers (answer only the questions that correspond to your activities):
    0= Never
    1= Some of the time
    2= Half the time
    3= Most of the time
    4= Always

_____ Receptive Anal Sex/Fucking
_____ Insertive Anal Sex/Fucking
_____ Receptive Oral Sex/Blowjob
_____ Insertive Oral Sex/Blowjob
_____ Receptive Anilingus/Rimming
_____ Insertive Anilingus/Rimming

APPENDIX C

(continued)

16. In the past 6 months, which behaviors below indicate those you have tried in order to avoid HIV transmission? (check all that apply)
    - __I have had only one sex partner, and we both are monogamous.
    - __I have had sex with fewer partners.
    - __I have been more careful about choosing my sex partners.
    - __I no longer have sex when I'm drunk or high.
    - __I have avoid places where unsafe sex is likely to happen.
    - __I have had less anal sex.
    - __I haven't let my sex partner(s) cum in my ass.
    - __I have stopped having anal sex altogether.
    - __I have less oral sex.
    - __I haven't let my sex partner (s) cum in my mouth.
    - __I have used condoms when having oral sex.
    - __I have stopped having oral sex altogether.
    - __Other
    - __None of the above: I have not been sexually active in the last 6 months.

17. Have you participated in any sexual activities during the last 6 months that you consider unsafe or possibly unsafe.
    _____Yes _____No (skip question 16)

18. Which if any of the following do you think best describes why you had unsafe or possibly unsafe sex? (check all that apply)
    - ___No condom was available.
    - ___I was drunk or high.
    - ___Safer sex was not convenient.
    - ___Safer sex is not satisfying to me.
    - ___I was turned on and didn't want to stop what I was doing.
    - ___I don't like condoms.
    - ___I was not comfortable asking my partner to practice safer sex.
    - ___My partner was attractive.
    - ___I was afraid my partner would not have sex with me if I insisted on safer sex.
    - ___My partner and I are both HIV-negative, and we don't have sex with others.
    - ___My partner and I are both HIV-postive, and we don't have sex with others.
    - ___I didn't know at the time that it was risky behavior.
    - ___I know what the risk is, and I choose to take it.
    - ___I don't know the reasons.
    - ___Other

19. Have you met any new sex partners in the past 6 months?
    ____Yes_____No (skip question 20)

APPENDIX C

(continued)

20. If yes, please mark how often you have met sex partners in each of the places below, using the following scale:
    F= Frequently S= Sometimes N=Never

___personal ads
___gay bars or clubs
___bathhouses
___parties
___gym
___work
___public restrooms
___Other:_____

____gay social events
____adult bookstores
____through friends
____rest stops
____parks
____Internet/chat rooms
____adult phone lines

APPENDIX D

SATISFACTION SCALE

DEEPER LOVE

PROGRAM EVALUATION/ GROUP SATISFACTION SCALE

Please rate the value of each item on the following 5-point scale:

strongly disagree	disagree	neutral	agree	strongly agree
1	2	3	4	5

The length of the course (5 weeks) worked for me.
1 2 3 4 5
The length of each class (2 1/2 hours) worked for me.
1 2 3 4 5
Comments/suggestions:

The location/setting was appropriate for the workshop.
1 2 3 4 5
How would you rate the facilitator?
The facilitator actively encouraged participation from the group.
1 2 3 4 5
The facilitator had considerable knowledge of the topics presented.
1 2 3 4 5
The facilitator was skilled and appeared qualified to lead the group.
1 2 3 4 5

Comments/suggestions:

_____
_____
_____
_____
_____
_____

Please rate each of the statements below as they relate to the group experience you have just completed using the scale below. Please indicate the degree to which you agree or disagree with each statement.

strongly disagree		neutral		strongly agree
1	2	3	4	5

___1. As a result of my group experience, I understand myself better.
___2. I received help with concerns other than my original reasons for attending the group.

APPENDIX D

(continued)

___3. I feel that these groups can help others with personal concerns.
___4. I was able to meet my goals form my group experience.
___5. Others in the groups helped me in dealing with my personal concerns.
___6. I believe I was able to help others in the group.
___7. I feel better about myself after being in the group.
___8. I can use what I learned in the group to improve my relationships with others.
___9. For the most part, I believe I was a valuable member of the group.
___10. I would recommend a similar group to a friend.
___11. I would like to continue meeting with group members.
___12. I know more about the transmission of HIV/STD's.
___13. I feel more empowered in our fight against the HIV epidemic.
___14. I am more aware of barriers to HIV prevention in the African American MSM population.
___15. I know of more activities and services for the African American MSM population.

PERSONAL FEEDBACK

Please share one or tow behavior and/or attitude changes influenced by your attending the Deeper Love workshop:

_____
_____
_____
_____

Things I liked about the Deeper Love workshop:

_____
_____
_____
_____

Things I disliked (or would like to see improved) about the Deeper Love workshop:

_____
_____
_____
_____
_____

APPENDIX E

INFORMED CONSENT

During October and November 2002, students of the Clark Atlanta University School of Social Work will be conducting a program evaluation of the Deeper Love Workshop of AID Atlanta. The purpose of the evaluation is to determine the effectiveness of the program and to provide the agency with valuable information for future enhancement. A comparison will be made of the participants' pre-test scores, post-test scores, satisfaction scales, and the follow-up scores collected at three months after completion of the workshop. In addition, an interview will be conducted of the program facilitators.

The data required will be kept confidential and will not include any identifying information of the program participants. Participation in the program evaluation is voluntary; those who elect to participate will remain anonymous. If you agree to sign and date this form, it gives permission for Clark Atlanta University to review and analyze the data that the agency has collected over the past three years and to interview program facilitators.

Signature:_____

Signature:_____

Signature:_____

Date:_____

APPENDIX F

STANDARD DEVIATIONS

Below are the mean and standard deviations for Questionnaire 1.

QUESTIONS	MEAN	STANDARD DEVIATION
1.I have had protected anal sex.	1.8667	1.0601
2. I have had protected oral sex.	3.4667	1.6417
3. The use of condoms interferes with my sexual pleasure.	4.3077	.9473
4. Condoms ruin the mood.	3.6667	1.5430
5. I feel in control of my sexual encounters.	1.8000	.8619
6. Has your personal self-esteem felt low.	2.8667	1.1872
7. My sexual behavior has put me at risk for HIV/STD's.	2.8000	1.1464
8. I feel comfortable discussing HIV with my sexual partner (s).	2.0667	1.2228
9. I am able to effectively communicate my desires to my partner (s).	1.9333	.8837
10. I am aware of the attributes that I desire for my romantic relationship (s).	1.5714	.6462
11. Using condoms can be pleasurable.	5.0714	1.3281

APPENDIX F

(continued)

12. I think condoms are an excellent means of protection.	5.7333	.5936
13. Condoms are unreliable.	2.5333	1.5055
14. I feel confident that I can use a condom effectively.	5.8000	.4140
15. I plan to use a condom every time I engage in sexual intercourse.	5.0667	1.1629
16. Condoms make intercourse completely safe.	1.9333	.2582
17. Oral sex is safe if partners do not swallow.	1.8667	.3519
18. By reducing the number of sexual partners, you are effectively protected from AIDS.	1.7333	.4577
19. A cure for AIDS is expected within the next two years.	1.9333	.4972
20. A positive result on the AIDS virus antibody test can occur even for people who do not carry virus.	1.3571	.4972
21. A great deal is known about AIDS.	1.1429	.3631
22. Based on your behavior in the last year, what do you think is your risk for getting HIV/AIDS?	2.4000	1.2984
23. Based on your behavior in the past month, what do you think is your risk for getting HIV/AIDS?	1.667	1.1127
24. Anal sex without a condom until ejaculation-inserting your penis in partner.	4.2000	1.1464
25. Anal sex without a condom until ejaculation-your partner inserts his penis in you.	4.4000	1.1832
26. Anal sex without a condom and withdrawing before ejaculating-inserting your penis.	4.2667	1.228

APPENDIX F

(continued)

27. Anal sex without a condom and withdrawing before ejaculation-partner inserts penis.	4.4000	1.0556
28.Anal intercourse with condom-your partner inserts his penis in you.	2.4667	.6399
29. Oral sex without a condom with ejaculating in your partner's mouth.	3.4667	1.4573
30. Oral sex without a condom - your partner inserting his penis and ejaculating in your mouth.	4.2000	1.2071
31. Deep Kissing.	1.9333	1.2228
32. Oral sex with condom-inserting your penis in your partner's mouth.	2.2000	1.2649
33. Oral sex with a condom-your partner inserts his penis in your mouth.	2.2000	1.2071
34. Oral sex-partner licking your shaft or balls with putting his mouth on the penis head.	1.8667	.9904
35. Oral sex- you lick partner's shaft or balls without putting your mouth on penis head.	1.8667	1.0601
36. I came to the class to make new friends.	3.8667	1.5976
37. I cam to this class to meet cute guys.	2.6000	1.7238
38. I came to this class to learn about what constitutes risky behaviors.	3.4286	1.6968
39. I am willing to alter the behaviors which place me at risk for HIV.	4.9286	1.2688
40. As a result of the DLW, I feel empowered to make better decisions, sexual practices.	5.1333	1.4573
41.As a result of the DLW, I feel more supported to make better decisions, sexual practices.	5.1333	1.1872
42. As a result of the DLW, I feel more knowledgeable about the transmission of HIV.	5.1333	1.5055

APPENDIX F

(continued)

43. I make good decisions.	4.8571	.8644
44. It is easy for me to make new friends.	4.7333	1.1629
45. I was truthful in answering these questions.	5.6667	.8165
46. Have you ever been told by health professions that you were HIV infected or you have AIDS.	2.000	.9258

Below are the mean and standard deviations for Questionnaire #2.

QUESTIONS	MEAN	STANDARD DEVIATION
1. You can catch HIV from mosquitoes.	1.8125	.4031
2. Immediately after HIV infection, a person can test negative for HIV, still infected.	1.0625	.2500
3. HIV is found in high concentration to be infectious-blood.	1.0000	.0000
4. HIV is found in high concentration to be infectious-sweat.	1.8667	.3519
5. HIV is found in high concentration to be infectious-semen.	1.0000	.0000
6. HIV is found in high concentration to be infectious- breast milk.	1.0000	.0000
7. HIV is found In high concentration to be infectious- saliva.	1.6875	.4787
8. HIV is found in high concentration to be infectious- vaginal secretions.	1.0000	.0000
9. Once infected with HIV, a person is infected for life.	1.0625	.2500

APPENDIX F

(continued)

10. If you are infected with HIV, you have AIDS.	2.0000	.0000
11. All persons with HIV/AIDS will benefit from current drug treatment.	1.8125	.4031
12. If used properly, condoms offer 100% protection against the transmission of HIV/STD's.	1.8667	.3519
13. Oral sex can transmit HIV/STD's.	1.0000	.0000
14. There are many people infected with HIV who look healthy and feel well, transmit.	1.0000	.0000
15. The number of new HIV infections in the U.S. is declining.	1.9333	.2582
16. By Georgia law, a person living with HIV is required to share information with partner.	1.1250	.3416
17. Have you been tested for HIV.	3.3125	.8732
18. What was the result of your last HIV test?	2.0000	.3780
19. In the past six months, what behaviors indicate those you have tried to avoid HIV.	11.1333	5.1667
20. Have you participated in any unsafe or possibly unsafe sexual practices past six months.	1.7143	.4688
21. Which if any of the following best describes why you had unsafe or possibly unsafe sex?	11.0000	6.4420

APPENDIX F

(continued)

Below are the mean and standard deviations for the satisfaction and program evaluation scales.

QUESTIONS	MEAN	STANDARD DEVIATION
The length of the course (5 weeks) worked for me.	4.4643	1.0357
The length of each class (2.5 hours worked for me.	4.3214	1.1564
The location/setting was appropriate for the workshop.	4.3929	.8317
The facilitator actively encouraged participation from the group	4.7500	.5853
The facilitator had considerable knowledge of the topics presented.	4.6429	.5587
The facilitator was skilled and appeared qualified to lead the group.	4.7500	.5853
As a result of my group experience, I understand myself better.	4.0000	.9428
I received help with concerns other than my original reasons for attending.	3.9643	.9616
I feel that these groups can help others with personal concerns.	4.6071	.6289
I was able to meet my goals for my group experience	4.0000	1.0184
Others in the group helped me in dealing with my personal concerns.	4.2500	.8872
I believe I was able to help others in the group.	4.1786	.9049
I feel better about myself after being in the group.	4.2143	.9567
I can use what I learned in the group to improve my relationships with others.	4.5000	.9230
For the most part, I believe I was valuable member of the group.	4.2857	.9759

APPENDIX F

(continued)

I would recommend a similar group to a friend.	4.7143	.5998
I would like to continue meeting with group members.	4.6429	.6785
I know more about the transmission of HIV/STD's.	4.2857	.8968
I feel more empowered in our fight against the HIV epidemic.	4.3929	.8317
I am more aware of barriers to HIV prevention in the African-American MSM population.	4.3214	1.0203
I know of more activities and services for the African-American MSM population.	308571	1.2971

Below are the mean and standard deviations for the three month follow-up questionnaire.

Behavior within Past 6 Months

QUESTIONS	MEAN	STANDARD DEVIATION
Test for HIV	3.25	1.164
HIV Results	1.90	.308
Receptive Anal Sex	2.00	1.188
Insertive Anal Sex	2.00	1.257
Receptive Oral Sex	2.37	1.212
Insertive Oral Sex	2.70	1.302
Receptive Rimming	1.95	1.177
Insertive Rimming	2.05	1.268

APPENDIX F

(continued)

Behavior within Past 6 Months with Condom

QUESTIONS	MEAN	STANDARD DEVIATION
Receptive Anal Sex	1.81	1.905
Insertive Anal Sex	2.06	1.769
Receptive Oral Sex	.59	1.004
Insertive Oral Sex	.50	.894
Receptive Rimming	.36	.929
Insertive Rimming	.21	.802

Behavior within Past 6 Months to Avoid HIV Transmission

QUESTIONS	MEAN	STANDARD DEVIATION
One Partner, Monogamous	1.45	.510
Few Partners	1.65	.489
Careful Choosing Partners	1.55	.510
High/Drunk during Sex	2.00	.000
Avoid Unsafe Sex Places	1.75	.444
Less Anal Sex	1.80	.410
No Anal Ejaculation	1.65	.489
Stopped Anal Sex	1.90	.308
Less Oral Sex	2.85	4.522
No Oral Ejaculation	1.60	.503
Use of Dental Dam	1.90	.308
Stopped Oral Sex	2.00	.000

APPENDIX F

(continued)

Unsafe Sexual Behavior within Past 6 Months

QUESTIONS	MEAN	STANDARD DEVIATION
Unsafe Acts w/in 6 Months	1.40	.503
No Condom Available	1.95	.224
Drunk/High during Sex	1.90	.308
Safe Sex Inconvenient	1.95	.224
Safe Sex Unsatisfactory	1.80	.410
Aroused & Didn't Stop	1.85	.366
Dislike Condoms	1.85	.366
Uncomfortable Asking Safe Sex	1.85	.366
Attractive Partner	1.90	.308
Safe Sex Rejection	1.95	.224
HIV Negative, Monog	1.65	.489
HIV Positive, Monog	2.00	.000
Unaware of Risks	1.95	.224
Aware of Risks	1.60	.503
Don't Know Reasons	1.80	.410

APPENDIX F

(continued)

New Partner within Past 6 Months

QUESTIONS	MEAN	STANDARD DEVIATION
New Partner w/in 6 Months	1.75	.444
Met through Personal Ads	2.71	.488
Met at Gay Bar/Club	2.00	.816
Met at Bathhouse	3.00	.000
Met at Party	2.14	.690
Met at Gym	2.71	.488
Met at Work	2.86	.378
Met at Public Restroom	3.00	.000
Met at Gay Social Events	2.29	.756
Met at Adult Bookstore	3.00	.000
Met through Friends	2.00	.577
Met at Reststop	3.00	.000
Met at Park	2.71	.488
Met through Chatroom	2.43	.535
Met on Adult Phoneline	2.71	.488

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